

CFC/PAS MEMBER REFERRAL☐ AB-CFC ☐ SD-CFC ☐ ABPAS ☐ SDPAS☐ Initial ☐ Readmission ☐ Short Term ☐ Change

Medicaid ID#	Last Name	First Name		DOB
Street Address	City	Zip	Home Phone	Cell Phone
Mailing Address	City	Zip	Message Phone	
RESPONSIBLE PARTY				
Name	<input type="checkbox"/> Member <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative (SD only – if other than member) <input type="checkbox"/> Contact Person (AB only - if other than member)			
Street Address	City	Zip	Home Phone	Cell Phone
Mailing Address	City	Zip	Work Phone	
<input type="checkbox"/> CHANGE IN OPTION (select one): <input type="checkbox"/> AB-CFC to SD-CFC <input type="checkbox"/> SD-CFC to AB-CFC <input type="checkbox"/> ABPAS to SDPAS <input type="checkbox"/> SDPAS to ABPAS <input type="checkbox"/> PAS to CFC (evaluate LOC)				
NEW PERSONAL REPRESENTATIVE (PR) INFORMATION: Name: Address: Phone: Reason for new PR:		CHANGE IN AGENCY New Agency Name: Agency Representative: Phone:		
Directions to home and other pertinent information:				
PERSONAL CARE NEEDS				
<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Hygiene	<input type="checkbox"/> Toileting <input type="checkbox"/> Transfer <input type="checkbox"/> Position	<input type="checkbox"/> Mobility <input type="checkbox"/> Meal <input type="checkbox"/> Eating	<input type="checkbox"/> Exercise <input type="checkbox"/> Medication Reminder <input type="checkbox"/> PERS	<input type="checkbox"/> IADLs (Describe):
COMMENTS RELATED TO PERSONAL CARE NEEDS:				
HEALTH MAINTENANCE ACTIVITIES (Self Direct referrals only) <input type="checkbox"/> Urinary Systems Management <input type="checkbox"/> Bowel Care <input type="checkbox"/> Medication Administration <input type="checkbox"/> Wound Care				
HEALTH CARE PROFESSIONAL				
Health Care Professional Name:		Telephone:		
LIST EACH RELEVANT MEDICAL DIAGNOSIS				
REFERRAL SOURCE				
Name	Agency	Phone	Fax	
Address	City	Zip	Date	
HIGH RISK				
High Risk Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason?				
Date Services Instituted:				
Number of Days Biweekly (Every Two Weeks) : ____ Number of Units Biweekly (Every Two Weeks): ____				
1 unit = 15 Minutes				